TTY/TTD: 1-800-772-7647 313-9240 in Nashville area SI HABLA ESPAÑOL, Tel. 1-800-254-7568

TENNCARE DRUG STORE NOTICE
(Top section to be completed by the Pharmacy)

Drug Store Name_____Phone Number_____Pharmacist's Initials _____

Today's Date:_____ Enrollee Name:_____ Soc. Sec. #:_____
Doctor's name:_____Phone# _____ Medicine ordered:_____

We cannot fill your prescription now.

1. ☐ Your doctor did not prescribe a TennCare drug or get TennCare to OK this drug. If this reason is checked, TennCare can pay for a supply of your drug (three days of medicine). Just ask for it. **If you do not get a supply of medicine, call TennCare Solutions at 1-800-878-3192 right away** (free call).
   Do you need this medicine for more than three days? TennCare will talk to your doctor about your medicine. All you need to do is come back to this drug store **in four days or before your three day supply is gone**. You will get the medicine that your doctor wants you to have. (You should call this drug store before you come back. Ask if your medicine is ready.) **Don't have a ride back to this drugstore?** Call your TennCare plan as soon as possible. **If you do not get more medicine when you come back you can appeal. You will have 30 days to appeal.**
   If you do not get any medicine today, **you can appeal now**. Fill out the bottom of this form. Or call TennCare Solutions at 1-800-878-3192. You will not get any medicine today if:
2. ☐Taking this drug could be a danger to your health.
3. ☐ The federal government has decided that this drug does not work as well as other similar medicines.
4. ☐ This drug is part of a group of drugs that TennCare does not cover for adults.
5. ☐ You did not accept the generic medicine that your doctor prescribed and we offered to you.

Need help? Call TennCare Solutions at **1-800-878-3192** (free call).

I got this form at the drugstore: Yes_____ No _____
Patient signature: X_____

I got part of my medicine and TennCare paid for it: Yes ____ No _____(**If you do not get more medicine when you come back, you can appeal. You will have 30 days to appeal.)**
Patient Signature: X_____

I paid for my medicine: Yes_____ **No** ____ **(If you paid for your medicine you have 30 days to appeal.)**
Patient Signature:X _____

TENNCARE APPEAL FOR MEDICINE
(To be Filled Out by Patient)

X_____Sign here to appeal. I want to appeal and it is OK for TennCare to see my medical records. If I got part of my medicine at the drug store, I want to keep getting the medicine as the doctor ordered or until my appeal is over. I understand my appeal is over when I get all the medicine my doctor ordered.

Name of person filling out form_____Phone#_____

Address: _____ City:_____ State: _____

Zip Code: _____ Daytime Phone ( )_____
Area code

Fill out the bottom of this form. Fax the whole page to **TennCare Solutions** at **1-888-345-5575** (toll free)**. OR Mail** it to **TennCare Solutions** at **PO Box 000593, Nashville, TN 37202-0593.**
Questions? Want to appeal by phone? **Call 1-800-878-3192** (free call).